Filing at a Glance

Company:	Golden Rule Insurance Company
Product Name:	Policy Change Application
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	12/03/2012
SERFF Tr Num:	AULD-128775056
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	I-21431 MIB GR
Implementation Date Requested:	On Approval
Author(s):	Angie Neville, Danita Ragland-Hatton, Kathy Roush
Reviewer(s):	Linda Bird (primary)
Disposition Date:	12/05/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Golden Rule Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Policy Change Application*
Project Name/Number: *Policy Change Application/I-21431*

General Information

Project Name: Policy Change Application
Project Number: I-21431
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Danita Ragland-Hatton

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 12/05/2012
State Status Changed: 12/05/2012
Created By: Danita Ragland-Hatton
Corresponding Filing Tracking Number:

Filing Description:

This filing is for the sole purpose of revising the MIB authorization language on our Policy Change Application, form I-21431, which was approved in your state on January 19, 2011 under SERFF Filing # AULD-126914694 and AR File number 47710. Filings for the other companies listed have been submitted under separate SERFF Filing numbers.

The following sentence has been added to the Authorization and Acknowledgement section: “I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB.

We certify that this is the only language change to this form.

Thank you for your time and consideration in reviewing this submission. If you have any questions, please feel free to contact me.

Company and Contact

Filing Contact Information

Kathy Roush,
One American Square
Indianapolis, IN 46206

317-285-7027 [Phone]
317-285-5510 [FAX]

Filing Company Information

Golden Rule Insurance Company
One American Square
P. O. Box 406
Indianapolis, IN 46206
(877) 285-7660 ext. [Phone]

CoCode: 62286
Group Code: 707
Group Name:
FEIN Number: 37-6028756

State of Domicile: Indiana
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking #: *AULD-128775056* ***State Tracking #:*** ***Company Tracking #:*** *I-21431 MIB GR*

State: *Arkansas* ***Filing Company:*** *Golden Rule Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *Policy Change Application*
Project Name/Number: *Policy Change Application/I-21431*

Company	Amount	Date Processed	Transaction #
Golden Rule Insurance Company	$50.00	12/03/2012	65379991

SERFF Tracking #:	*AULD-128775056*	***State Tracking #:***		***Company Tracking #:***	*I-21431 MIB GR*

State:	*Arkansas*	***Filing Company:***	*Golden Rule Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Policy Change Application*		
Project Name/Number:	*Policy Change Application/I-21431*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	12/05/2012	12/05/2012

SERFF Tracking #:	*AULD-128775056*	***State Tracking #:***		***Company Tracking #:***	*I-21431 MIB GR*

State:	*Arkansas*	***Filing Company:***	*Golden Rule Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Policy Change Application*		
Project Name/Number:	*Policy Change Application/I-21431*		

Disposition

Disposition Date: 12/05/2012
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Third Party Authorization		Yes
Supporting Document	Statement of Variability		Yes
Form	Policy Change Application		Yes

SERFF Tracking #:	*AULD-128775056*	***State Tracking #:***		***Company Tracking #:***	*I-21431 MIB GR*

State:	*Arkansas*	***Filing Company:***	*Golden Rule Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Policy Change Application*		
Project Name/Number:	*Policy Change Application/I-21431*		

Form Schedule

Lead Form Number: I-21431

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1		Policy Change Application	I-21431	AEF	Revised	Previous Filing Number:	AULD-126914694 / 47710	50.200	I-21431 09-17-12.pdf
						Replaced Form Number:	Same		

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

POLICY CHANGE APPLICATION
(Please print in dark ink.)

American United Life Insurance Company®
a OneAmerica® company
One American Square
P.O. Box 6003
Indianapolis, IN 46206-6003
1-800-537-6442

Pioneer Mutual Life Insurance Co.
A stock subsidiary of American United Mutual Insurance Holding Company
a OneAmerica® company
P.O. Box 6003
Indianapolis, IN 46206-6003
1-800-437-4692

The State Life Insurance Company
a OneAmerica® company
P.O. Box 6003
Indianapolis, IN 46206
1-800-275-5101

OneAmerica®

Check all that apply:
☐ **American United Life Insurance Company®**
☐ **The State Life Insurance Company**
☐ **Pioneer Mutual Life Insurance Company**
☐ **Golden Rule Insurance Company**
Administered by The State Life Insurance Company

Hereinafter referred to as "the Company."

PART I – Requested Change Always complete PART I and PART V

Please print all information.

Policy Number(s): _____

Insured: _____

Owner: _____

MARK THE BOX FOR EACH CHANGE AND COMPLETE THE APPROPRIATE SECTION(S).

☐ **Add/Cancel Rider/Benefit** – **Part II** Section 4 required.
- **Addition of Rider/Benefit** – also complete **Part III** & IV.**
- **Addition of Child Benefit Rider** – also complete **Part III**** for the base insured on the policy plus all children to be covered under this rider.

☐ **Cancel One Year Term Dividend Option – Part II** Section 4 required.

☐ **Child Benefit Rider Conversion** – **Part II** Section 1 required.
- **Increase in total coverage, additional benefits or DB Option 2(B)** – also complete **Part III** & IV.**

☐ **Conversion of** _____ **(indicate Term Plan or Term Rider)**
- **New policy – Part II** Section 1 required.
- **Increase to an existing UL or VUL – Part II** Section 3 required.
- **Increase in total coverage, additional benefits or DB Option 2(B)** – also complete **Part III** & IV.**

☐ **Full Conversion** ☐ **Partial Conversion** **Amount to convert** $_____

If Partial conversion, balance of remaining term (subject to meeting Company minimum amounts) to be:
☐ **Continued – Amount** $_____
☐ **Added as a term rider on the new plan – Type of term rider** _____
Face amount of term rider $ _____

☐ **Discontinue Policy**

☐ **Exchange of Dividend Accumulations for Paid Up Additions – Part III**** required.
- **Death Benefit increase $10,000 or greater** – also complete **Part IV.**

CONTINUED ON PAGE 2

PART I – Requested Change (continued) Always complete PART I

☐ **Exercise Guaranteed Purchase Option, Additional Insurance Option, Guaranteed Purchase Plan or Guaranteed Insurability Option**

- **New policy – Part II** Section 1 required.
- **Increase to an existing UL or VUL – Part II** Section 3 required.
- **Increase in total coverage, additional benefits or DB Option 2(B)** – also complete **Part III** & IV.**

☐ **Alternate Option**

Reason for Alternate Option _____ **Date of applicable event** _____

If due to birth or adoption, give number of children born or legally adopted on the same date. _____

☐ **Increase/Decrease Base Policy/Specified Amount or Rider – Part II** Section 3 required.

- **Increase Base Policy/Specified Amount or Rider** – also complete **Part III** & IV**.

☐ **Plan or Death Benefit Option Change – Part II** Section 2 required.

- **Changing DB Option from Option 1(A) to Option 2(B) or from Option 3(C) to Option 2(B)** – also complete **Part III** & IV.**

☐ **Rate Classification – Change or Remove – Part III**** required

☐ **Reinstatement – Parts III** & IV** required

☐ **Reissue** (within 60 days of Issue Date)** – Complete applicable sections.

☐ **Other** _____

Notice Regarding Insurance Being Converted or Reissued:

The undersigned surrenders to the Company the insurance being converted or reissued and requests there be issued in substitution the new plan of insurance effective the date of the new coverage. The new coverage will be subject to any existing written assignment of the original policy.

****THESE REQUESTS ARE SUBJECT TO MEDICAL UNDERWRITING AND THE COMPANY MUST APPROVE AND AGREE TO THESE REQUESTS.** *HIPAA form also required if there is not a valid one on file.*

Special Requests/Additional Instructions

END OF PART I

PART II – New Policy Information and/or Requested Change Details

SECTION 1 Required for new Policy. Optional for changes to existing policy.

A. Insured Information

Insured's Name _____
First *MI* *Last*

☐ Male ☐ Female Insured's Birth Date _____ Insured's SSN _____

Insured's Address _____

B. Owner and Payor Information

Complete Owner information only if different from Primary Insured.

All notices and correspondence will be sent to the Owner.

If there are to be multiple owners, complete the Request for Multiple Ownership form. If the owner is a Trust or Corporation, provide a copy of the Trust Agreement or Corporate Resolution.

Owner's Full Name _____
First *MI* *Last*

Relationship to Insured _____

Name of Corporation, Trust or Qualified Retirement Plan _____

Full Name of Corporate Officer or Trustee, Title and State of Incorporation _____

Custodian Name _____

Custodian Under _____ (State) ☐ UGMA ☐ UTMA

☐ Male ☐ Female ☐ Corporation ☐ Trust ☐ Qualified Retirement Plan ☐ Other _____

Owner's Birth Date or Date of Trust _____ Owner's SSN or Tax ID # _____

Owner's Address _____

Phone Number _____ E-mail Address _____

Payor Name and Address (if other than Owner) _____

C. Contingent Owner Information

Full Name _____
First *MI* *Last*

Relationship to Insured _____

☐ Male ☐ Female ☐ Other _____ Birth Date _____ SSN or Tax ID # _____

Contingent Owner's Address _____

Phone Number _____ E-mail Address _____

D. Primary Beneficiary (continued on page 4)

Unless otherwise directed, the policy proceeds shall be divided equally among all persons who are named as primary beneficiary.

Please select one:

☐ **Benefit Paid Equally** The policy proceeds will be divided equally among all persons who are named as primary beneficiary and who survive the insured

☐ **Benefit % Designated** ***(benefit amounts completed below must total 100%)*** If you have named more than one primary beneficiary by percentages and less than all of the beneficiaries named predecease the insured(s); then a predeceased beneficiary's portion should be paid:

- ☐ in proportionate shares to the remaining living beneficiary or beneficiaries
- ☐ to the policy owner
- ☐ to that deceased beneficary's heirs.

PART II – New Policy Information and/or Requested Change Details (continued)

SECTION 1 (continued) Required for new Policy. Optional for changes to existing policy.

D. Primary Beneficiary (continued)

Full Name or Name of Corporation/Trust _____

☐ Male ☐ Female % of Benefit: _____

Relationship to Insured or State of Incorporation _____

Birth Date or Date of Trust _____ SSN or Tax ID # _____

Address _____

Full Name or Name of Corporation/Trust _____

☐ Male ☐ Female % of Benefit: _____

Relationship to Insured or State of Incorporation _____

Birth Date or Date of Trust _____ SSN or Tax ID # _____

Address _____

E. Secondary Beneficiary (applicable if no primary beneficiary survives the insured)

Unless otherwise directed, the policy proceeds shall be divided equally among all persons who are named as secondary beneficiary.

Please select one:

☐ **Benefit Paid Equally** The policy proceeds will be divided equally among all persons who are named as secondary beneficiary and who survive the insured

☐ **Benefit % Designated** ***(benefit amounts completed below must total 100%)*** If you have named more than one secondary beneficiary by percentages and less than all of the beneficiaries named predecease the insured(s); then a predeceased beneficiary's portion should be paid:

- ☐ in proportionate shares to the remaining living beneficiary or beneficiaries
- ☐ to the policy owner
- ☐ to that deceased beneficary's heirs.

Full Name or Name of Corporation/Trust _____

☐ Male ☐ Female % of Benefit: _____

Relationship to Insured or State of Incorporation _____

Birth Date or Date of Trust _____ SSN or Tax ID # _____

Address _____

Full Name or Name of Corporation/Trust _____

☐ Male ☐ Female % of Benefit: _____

Relationship to Insured or State of Incorporation _____

Birth Date or Date of Trust _____ SSN or Tax ID # _____

Address _____

F. Plan of Insurance _____ **Face Amount $** _____

Death Benefit Option (UL/VUL): Refer to base plan for availability. (May not be available in all states.)

☐ Option 1(A) Level Death Benefit ☐ Option 2(B) Increasing Death Benefit

☐ Option 3(C) Return of Premium

PART II – New Policy Information and/or Requested Change Details (continued)

SECTION 1 (continued) Required for new Policy. Optional for changes to existing policy.

Riders/Benefits to be included *(May not be available in all states)* **G., H. and I.**

G. Whole Life Plan only Refer to base plan for availability. If adding a new rider or benefit, complete **PART III and IV**.

- ☐ Blended Insurance Rider (BIR) $ _____ ☐ Child Benefit Rider (CBR) _____ units
- ☐ Enhanced Blended Insurance Rider (EBIR) $ _____ Premium $ _____
- ☐ Coverage Builder Rider: Planned Prem. $_____ ☐ Guaranteed Insurability Option (GIO) $ _____
- ☐ Paid Up Additions Disability Rider $_____ ☐ Premium Deposit Fund (PDF) $ _____
- ☐ Term Rider $_____ Name_____ Birth Date _____ ☐ M ☐ F
- ☐ Term Rider $_____ Name_____ Birth Date _____ ☐ M ☐ F
- ☐ Value Builder Rider (requires BIR/EBIR): Planned Premium $ _____
- ☐ Waiver of Premium Disability (WPD)
- ☐ Other _____

H. Universal Life (UL) Plan only Refer to base plan for availability. If adding a new rider or benefit, complete **PART III and IV**.

- ☐ Child Benefit Rider (CBR) _____ units
- ☐ Credit of Premium Disability (CPD) $ _____ monthly premium (must also request WMDD)
- ☐ Guaranteed Insurability Option (GIO) $_____
- ☐ Premium Deposit Fund (PDF) $ _____ ☐ Supplemental Face Amount $_____
- ☐ Term Rider $_____ Name_____ Birth Date _____ ☐ M ☐ F
- ☐ Term Rider $_____ Name_____ Birth Date _____ ☐ M ☐ F
- ☐ Waiver of Monthly Deduction (WMDD) required for CPD
- ☐ Other _____

I. Variable Universal Life (VUL) Plan only

- ☐ Credit of Premium Disability (CPD) $_____ monthly premium (must also request WMDD)
- ☐ Extended No Lapse Guarantee Rider
- ☐ Guaranteed Insurability Option (GIO) $_____ ☐ Premium Deposit Account (PDA) $ _____
- ☐ Supplemental Face Amount $_____
- ☐ Term Rider $_____ Name_____ Birth Date _____ ☐ M ☐ F
- ☐ Term Rider $_____ Name_____ Birth Date _____ ☐ M ☐ F
- ☐ Waiver of Monthly Deduction (WMDD) required for CPD
- ☐ Other _____

J. Dividend Option (Whole Life Only)

- ☐ Cash ☐ Accumulate at Interest
- ☐ Reduce Premium (annual payment method only) ☐ Paid Up Additions
- ☐ Other _____

K. Premium Information

Premium Amount $ _____ Payment Method ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly **APP***

☐ Offset premiums by surrendering PUAs in policy year _____

***If APP (Automatic Premium Plan) is chosen, please complete the following:**

☐ Add this premium to existing APP for Policy No. _____

☐ Start a new draft from the following account: ☐ Checking ☐ Savings

Account No. _____ Routing No. _____

Monthly Deduction Date (1st thru 28th) _____ Attach a blank voided check from this account for routing information.

PART II – New Policy Information and/or Requested Change Details (continued)

SECTION 1 (continued) Required for new Policy. Optional for changes to existing policy.

L. Nonforfeiture Option

☐ Automatic Premium Loan (APL) (if available) ☐ Qualified Retirement Plan

If nothing is checked, the APL option will be applied if applicable (except in Illinois). If Qualified Retirement Plan is selected, the automatic nonforfeiture option is paid up insurance.

SECTION 2: Change of Plan/Death Benefit Option Change

☐ Change Plan of Insurance from _____ to _____

☐ Change Death Benefit Option from _____ to _____

Change from Option 1(A) to Option 2(B) OR from Option 3(C) to 2(B) requires completion of PART III and IV.
Refer to base plan for availability.

SECTION 3: Increase/Decrease Base Policy/Specified Amount or Rider

For an increase in coverage, complete **Part III and IV**.

☐ Increase ☐ Decrease Base Policy from $_____ to $_____

☐ Increase ☐ Decrease Term Rider from $_____ to $_____

Planned Premium (UL/VUL) to: ☐ Remain the Same ☐ Changed to $_____

Must meet required minimum premium if policy is in its minimum premium period.

SECTION 4: Addition/Cancellation of Rider/Benefit

For addition of a new rider/benefit, also complete **Part III and IV**.
For a Child Benefit Rider, complete **Part III** for the base insured on the policy plus all children.

Rider/Benefits: *Addition of some Riders and Benefits only available for reissue within first 60 days.*
Refer to base plan for availability.

☐ Add ☐ Cancel Accelerator $_____ annual premium
☐ Add ☐ Cancel Accelerator ONE $_____ single premium
☐ Add ☐ Cancel Blended Insurance Rider (BIR) $ _____
☐ Add ☐ Cancel Enhanced Blended Insurance Rider (EBIR) $_____ Premium $ _____
☐ Add ☐ Cancel Change of Insured Rider
☐ Add ☐ Cancel Child Benefit Rider (CBR) _____ units
☐ Add ☐ Cancel Continuation of Benefit Rider
☐ Add ☐ Cancel Coverage Builder Rider Planned premium $ _____
☐ Add ☐ Cancel Credit of Premium Disability (CPD) *Must also request WMDD* $ _____
☐ Add ☐ Cancel Guaranteed Insurability Option (GIO) $ _____
☐ Add ☐ Cancel One Year Term Dividend Option - If canceling, select new Dividend Option:
  ☐ Cash ☐ Accumulate at Interest ☐ Paid Up Additions
  ☐ Reduce Premium (annual payment method only)
  ☐ Other _____
☐ Add ☐ Cancel Other Insured Rider $_____ on _____
☐ Add ☐ Cancel Other Insured Rider $_____ on _____
☐ Add ☐ Cancel Premium Deposit Fund (PDF)/Premium Deposit Account (PDA) $_____
☐ Add ☐ Cancel Same Insured Term Rider $ _____
☐ Add ☐ Cancel Supplemental Face Amount $_____
☐ Add ☐ Cancel Value Builder Rider (Requires BIR/EBIR) Planned premium $ _____
☐ Add ☐ Cancel Waiver of Premium Disability (WPD) $ _____
☐ Add ☐ Cancel Waiver of Monthly Deduction Disability (WMDD) required for CPD
☐ Add ☐ Cancel Other _____
☐ Add ☐ Cancel Other _____
☐ Add ☐ Cancel Other _____

END OF PART II

PART III – Underwriting Information

HIPAA *form is required if there is not a valid one on file*.

SECTION 1: Proposed Insured Information

Persons Proposed for Insurance: *(Give full names including spouse's maiden name)*							Ins. in Force	
Name	**Birth Date**	**Birth Place**	**Relationship**	**Sex**	**Height**	**Weight**	**Life**	**ADB**
Proposed Insured								
Family Members								

SECTION 2: Health Questions (Complete for all proposed insureds. Optional for those being examined.)

A. During the past ten (10) years has any person proposed for insurance been diagnosed as having, or been treated for:

	Primary Insured		Second/Other Insured	
1. Heart attack, high blood pressure, stroke, or other disorder of the heart or blood vessels?	☐ Yes	☐ No	☐ Yes	☐ No
2. Cancer, tumor, lymph gland or thyroid disorder, chronic fatigue, leukemia, or any other blood abnormalities?	☐ Yes	☐ No	☐ Yes	☐ No
3. Diabetes or other endocrine disorder; disorder of the kidney, bladder or prostate?	☐ Yes	☐ No	☐ Yes	☐ No
4. Lung or chronic respiratory disorder, asthma, bronchitis, emphysema, pneumonia, tuberculosis, or any other disorder of the respiratory system?	☐ Yes	☐ No	☐ Yes	☐ No
5. Intestinal bleeding, ulcer, hepatitis, or other disorder of stomach, liver, intestine, gall bladder or pancreas?	☐ Yes	☐ No	☐ Yes	☐ No
6. Any disease or disorder of the reproductive organs or breasts?	☐ Yes	☐ No	☐ Yes	☐ No
7. Brain, mental or nervous disorder, fainting, convulsions; paralysis, depression, anxiety, frequently recurring headaches or any other disease or disorder of the nervous system, attempted suicide or ever been counseled for any of the above?	☐ Yes	☐ No	☐ Yes	☐ No
8. Arthritis, loss of limb or deformity, disorder of bone, joint, muscle, back, spine or neck, skin disorder or any other disorder of the skeletal system?	☐ Yes	☐ No	☐ Yes	☐ No
9. Disease or disorder of the eyes, ears, nose or throat?	☐ Yes	☐ No	☐ Yes	☐ No
10. Has the proposed insured ever been diagnosed or treated by a member of the medical profession for specified symptoms such as: immune deficiency, anemia, recurrent fever, chronic fatigue or unexplained weight loss, malaise, loss of appetite, prolonged diarrhea, fever of unknown origin, severe night sweats, unexplained or unusual infections or skin lesions; unexplained swelling of the lymph glands; Kaposi's Sarcoma or Pneumocystis Carinii Pneumonia?	☐ Yes	☐ No	☐ Yes	☐ No
11. Has the proposed insured ever been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes	☐ No	☐ Yes	☐ No

PART III – Underwriting Information (continued)

SECTION 2: Health Questions (continued)

B. During the past five (5) years has any person proposed for insurance:

	Primary Insured		Second/Other Insured	
1. Been advised to take or is now taking treatment or medication or under prescribed diet?	☐ Yes	☐ No	☐ Yes	☐ No
2. Had a checkup or consultation with a physician or medical practitioner?	☐ Yes	☐ No	☐ Yes	☐ No
3. Had any diagnostic test, such as an EKG, treadmill, heart cath, X-ray, MRI, CT scan, biopsy or blood study?	☐ Yes	☐ No	☐ Yes	☐ No
4. Has been an inpatient or outpatient in a hospital, clinic or medical facility or any similar entity?	☐ Yes	☐ No	☐ Yes	☐ No
5. Been advised to have any diagnostic test, hospitalization or surgery which has not been completed?	☐ Yes	☐ No	☐ Yes	☐ No

C. Has or is any person proposed for insurance:

1. Pregnant? *If Yes, list the anticipated delivery date.* _____	☐ Yes	☐ No	☐ Yes	☐ No

During the past five (5) years:

2. Made a claim for or received benefits, compensation or pension for any injury, sickness, disability or impaired condition?	☐ Yes	☐ No	☐ Yes	☐ No
3. Been unable to work, attend school or perform the normal activities of like age and gender or been confined at home?	☐ Yes	☐ No	☐ Yes	☐ No
4. Required assistance for a period longer than 2 weeks to perform the following daily activities: bathing, dressing, walking, eating, using toilet, getting up and down, taking medication, shopping, or cooking?	☐ Yes	☐ No	☐ Yes	☐ No
5. During the last five years, had any illness, disease, or injury not mentioned above?	☐ Yes	☐ No	☐ Yes	☐ No

Provide details of all "Yes" answers. (Identify Primary or Second/Other Insured, question number, circle applicable items, include diagnosis, treatment, dates of diagnosis, dates of treatment, duration and names and addresses of all attending physicians and medical facilities.)

_____

_____

_____

_____

_____

_____

SECTION 3: Information Regarding other Coverage - Applies to all proposed insured(s) (continued on page 9)

a. Do you have existing life insurance or annuity(ies) with this or any other company? ☐ Yes ☐ No

b. Will this policy be replacing or changing any existing life insurance or annuity with this or any other company? ☐ Yes ☐ No If yes, provide details below.

c. List all life insurance or annuities in force on Proposed Insured(s):

				Replacement?		§1035
Amount	Issue Year	Type	Company / Policy No.	No	Yes	Exchange?

d. Is an application for life, health insurance or annuity pending with this or any other company?
If Yes, Company Name _____ Amount $_____ ☐ Yes ☐ No

PART III – Underwriting Information (continued)

SECTION 3: Information Regarding other Coverage - Applies to all proposed insured(s) (continued)

e. Have you ever sold a policy to a life settlement, viatical or other secondary market product provider, are you in the process of selling a policy, or planning a future sale? ☐ Yes ☐ No
If Yes, Company Name _____ Amount $ _____

f. If the proposed insured is a juvenile, what is the total amount of life insurance in force on the parent(s)?
$ _____ If not insured, why not? _____

Complete the following for all siblings:	Age	Amount in Force	Age	Amount in Force
	_____	$ _____	_____	$ _____
	_____	$ _____	_____	$ _____

SECTION 4: Personal Information (continued on page 10)

Complete for all proposed insureds and identify to whom any "Yes" answers apply. Provide details to any "Yes" answers below.

	Primary Insured		Second/Other Insured	
a. Driver's license number(s) and state(s) of Issue: Primary Insured: _____ Second/Other Insured: _____				
b. Have you been convicted of a driving violation, driving under the influence of alcohol or drugs, or had your license suspended or revoked?	☐ Yes	☐ No	☐ Yes	☐ No
c. Plead guilty to or been convicted of a felony or misdemeanor or do you have such charge currently pending against you? *If Yes, list the nature of the plea, conviction or charge, the date and State where the plea, conviction or charges occurred, whether time was served in prison and the status of probation.*	☐ Yes	☐ No	☐ Yes	☐ No
d. Has any company declined, postponed, rated or refused to reinstate insurance?	☐ Yes	☐ No	☐ Yes	☐ No
e. Has the proposed insured ever:				
1. Used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician?	☐ Yes	☐ No	☐ Yes	☐ No
2. Received medical treatment or counseling for, or been advised by a physician to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐ Yes	☐ No	☐ Yes	☐ No
3. Been a member of any self-help group such as Alcoholics Anonymous or Narcotics Anonymous?	☐ Yes	☐ No	☐ Yes	☐ No
f. Have you participated in any vehicle racing, parachuting, hang gliding, scuba diving, ballooning, rock or mountain climbing or spelunking within the past two (2) years or is any such activity contemplated within the next two (2) years? *If Yes, complete the Avocation Supplement.*	☐ Yes	☐ No	☐ Yes	☐ No
g. Have you flown within the past two (2) years as a pilot, student pilot, crew member or had any flying duties, or is any such activity contemplated within the next two (2) years? *If Yes, complete the Aviation Supplement.*	☐ Yes	☐ No	☐ Yes	☐ No
h. Do you contemplate travel or residence in a foreign country within he next 24 months? *If Yes, complete the Foreign Travel Supplement.*	☐ Yes	☐ No	☐ Yes	☐ No
i. Do you have any current or expected connection with the Armed Forces? *If Yes, complete the Armed Forces Supplement.*	☐ Yes	☐ No	☐ Yes	☐ No

PART III – Underwriting Information (continued)

SECTION 4: Personal Information (continued)

	Primary Insured	Second/Other Insured
j. Has the proposed insured ever used any nicotine (including substitutes such as gum, patch, etc.) and/or tobacco products?	☐ Yes ☐ No	☐ Yes ☐ No

If Yes, provide detail below.

1. ☐ Present ☐ Former
2. Type of nicotine or tobacco used: _____
3. When did you quit using all forms of nicotine (including substitutes) or tobacco? _____ month/year

Details of all "Yes" answers.

_____

_____

_____

_____

_____

_____

_____

_____

Names(s) and address(es) of personal physicians (If none, so state)

Primary Insured: _____

_____

Date and reason last consulted: _____

_____

List any medications taken daily: _____

_____

Second Insured: _____

_____

Date and reason last consulted: _____

_____

List any medications taken daily: _____

_____

Interview Information

Home Phone: _____ Best Time to Call _____ a.m. _____ p.m.

Business Phone: _____ Best Time to Call _____ a.m. _____ p.m.

May we interview the spouse or an adult member of the family? ☐ Yes ☐ No

PART IV – Annual Income of Proposed Insured

Earned $_____ Unearned $_____ Net Worth $_____

In the past seven (7) years, have you filed for bankruptcy? ☐ Yes ☐ No

Bankruptcy Type: ☐ Personal ☐ Business ☐ Other Date Discharged? _____

PART V – Information, Authorization and Signatures Always complete PART V

Agreements

I (we) represent that I (we) have read and understand all the statements and answers given in this application and that they are true and complete to the best of my (our) knowledge and belief. It is agreed that:

a. the statements and answers given to this application and any amendments to it or made to the medical examiner will be the basis of any insurance issued;

b. no representative or medical examiner has the authority to make or alter any contract for the company;

c. the company may indicate changes in an endorsement to this application for administrative purposes only, and I (we) must agree in writing to any other changes in this application;

I (we) and the representative certify that I (we) have read, or had read to me (us), the completed application and I (we) realize that any false statement or misrepresentation therein may result in loss of coverage under the policy.

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your policy.

Contestability

I (we) understand that, except for additional benefits provided by any attached agreements, any new policy applied for shall be incontestable when the policy or agreement containing the option or privilege being exercised is incontestable. If the date of issue of the policy applied for is within two years of the date of issue of the policy or agreement containing the option or privilege being exercised, the representations, statements and agreement made in the original application, except as they are modified by this application, are hereby renewed and shall become a PART of the new policy when issued. Additional benefits modified by this application shall be incontestable two years from the date of this application.

Authorization and Acknowledgement

I (we) authorize any physician, medical practitioner, hospital, medical facility, insurance company, DMV and the MIB to give all the companies who are listed as a OneAmerica® company and its reinsurers any of the following about me (us) or my (our) children, if they are to be insured: facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. Each person proposed for insurance may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and , where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. All sources except the MIB may give these facts to any insurance support organization authorized by a OneAmerica company to collect and transmit them. This data will be used to determine eligibility for insurance. I authorize any company listed as a OneAmerica company and its reinsurers to make a brief report of my personal health information to MIB. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date signed. I can choose to be interviewed if an investigative consumer report is made. Upon request, I (we) can receive a copy of the investigative consumer report. I(we) have received the Notice of OneAmerica's Information Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice, and the Authorization and Acknowledgement. I (we) or my (our) authorized representative can receive a copy of this authorization form.

FRAUD WARNING Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

(Continued on Page 12)

PART V – Information, Authorization and Signatures (continued)

Substitute W-9 Certification

I (we) certify, under penalty of perjury that (1) the number(s) shown on this form is (are) my (our) correct taxpayer identification number(s), or I (we) am (are) waiting for a number to be issued to me (us); and (2) I (we) am (are) not subject to backup withholding because: (a) I (we) am (are) exempt from backup withholding or (b) I (we) have not been notified by the Internal Revenue Service that I (we) am (are) subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me (us) that I (we) am (are) no longer subject to backup withholding; and (3) I (we) am (are) a U.S. citizen or other U.S. person (as defined in Form W-9 located at *www.irs.gov*).

☐ Check this box if you have been notified by the IRS that you are currently subject to withholding because of under reporting interest or dividends on your tax return.

THE INTERNAL REVENUE SERVICE DOES NOT REQUIRE YOUR CONSENT TO ANY PROVISION OF THIS DOCUMENT OTHER THAN THE CERTIFICATION REQUIRED TO AVOID BACKUP WITHHOLDING.

Signatures

Signed at _____ on _____ (mm/dd/yyyy)
City, State *Date*

Proposed Insured	_____	_____
Proposed Second/Other Insured	_____	_____
Proposed Other Insured #2	_____	_____
Proposed Other Insured #3	_____	_____
Owner or applicant other than proposed insured (If business insurance, show title of officer and name of firm)	_____	_____
Assignee, if applicable	_____ *Printed Name*	_____ *Signature*

Any child over age 15 proposed for insurance must sign. If proposed insured is under age 18, parent must also sign.

FOR VARIABLE PRODUCTS, PLEASE ACKNOWLEDGE

I hereby acknowledge receipt of the current prospectus, and any supplements for this policy including any required disclosure if the policy applied for will be in a qualified plan.

Please check, if applicable. ☐ Yes, I have a CD-ROM drive on my computer and am able to view all of the prospectuses.

For a printed version of the prospectuses, please call **1-800-537-6442**. *Variable contracts issued by AUL are distributed by OneAmerica Securities, Inc., Member FINRA, SIPC, a wholly-owned subsidiary of AUL.*

_____ _____
Signature *Date*

(Continued on Page 13)

PART V – Information, Authorization and Signatures (continued)

Representative's Statement/Signature

Do you have any knowledge or reason to believe that replacement of existing insurance or annuity coverage may be involved? ☐ Yes ☐ No

I certify that a written disclosure statement, where required by law, was given to the applicant when this application was taken. I have truly and accurately recorded on the application the information supplied by the applicant and/or proposed insured.

_____ _____
Name of Representative ***(Please print)*** *Representative's Signature*

_____ % _____ ☐ AUL ☐ PML ☐ State Life
Representative's Code

_____ _____
Name of Representative ***(Please print)*** *Representative's Signature*

_____ % _____ ☐ AUL ☐ PML ☐ State Life
Representative's Code

_____ _____
Name of Representative ***(Please print)*** *Representative's Signature*

_____ % _____ ☐ AUL ☐ PML ☐ State Life
Representative's Code

Agency or Broker/Dealer _____

If the Company has questions concerning this application, whom should we call at your office?

Name _____ Phone Number _____ Fax Number _____

E-mail Address _____

RECEIPT
(Applicant retains receipt upon completion.)

Received from _____ the sum of $ _____ made payable to

☐ American United Life Insurance Company®
☐ Pioneer Mutual Life Insurance Company
☐ The State Life Insurance Company

as a deposit in connection with a Policy Change Application. This deposit will be applied toward the premium that will be due if the Policy Change Application is approved by the above-referenced Company. This premium deposit DOES NOT provide the applicant any coverage until the Policy Change Application is approved and the Company issues evidence of coverage to the applicant. At that time, the Company will apply the deposit to the premium due. If the Company does not approve the Policy Change Application, the deposit will be returned to the applicant.

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE APPROPRIATE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE REPRESENTATIVE OR LEAVE THE PAYEE BLANK.

No representative has the authority to alter terms of this receipt in any way.

I have received and have read this receipt. It has been explained to me by the representative and I understand and agree to its terms.

_____ _____
Date *Signature of Proposed Insured*

_____ _____
Signature of Representative *Signature of Owner (If other than Proposed Insured)*

NOTE: If you do not receive communication from us on the status of your request or a refund of the amount you paid within 60 days from the date of this receipt, please notify AUL, PML or State Life, Post Office Box 6003, Indianapolis, IN 46206-6003, or call 1-800-537-6442. Give your name, the amount and date of this payment, and the name of the representative.

SERFF Tracking #:	*AULD-128775056*	***State Tracking #:***	***Company Tracking #:*** *I-21431 MIB GR*

State:	*Arkansas*	***Filing Company:***	*Golden Rule Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*Policy Change Application*		
Project Name/Number:	*Policy Change Application/I-21431*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
I-21431 Flesch Certification.pdf			

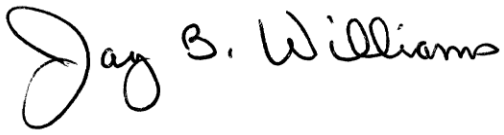
		Item Status:	**Status Date:**
Satisfied - Item:	Third Party Authorization		
Comments:			
Attachment(s):			
Golden Rule 3rd Party Authorization.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
SOV I-21431 STANDARD 11-30-12.pdf			

CERTIFICATE OF READABILITY

I, Jay B. Williams, Vice President of American United Life Insurance Company, Golden Rule Insurance Company, Pioneer Mutual Life Insurance Company and The State Life Insurance Company, hereby certify that the following form(s) have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements of your state.

FORM(S)		READABILITY SCORE
I-21431	Policy Change Application	50.2



December 3, 2012
Date

Jay B. Williams
Vice President
Chief Compliance Officer

Golden Rule®
A UnitedHealthcare Company

CERTIFICATE OF AUTHORIZATION

The undersigned hereby certifies that The State Life Insurance Company has the authority to act on behalf of Golden Rule Insurance Company for the sole purpose of filing policy form **I-21431 Policy Change Application** with the state Department of Insurance.

Authorized by:

GOLDEN RULE INSURANCE COMPANY

Signature: _____

Printed Name: Michael L. Cooke

Title: Vice President, Health Products and Regulatory Affairs

Date: 11/10/10

Golden Rule Insurance Company
712 Eleventh Street
Lawrenceville, Illinois 62439
www.goldenrule.com

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
www.goldenrule.com

American United Life Insurance Company
Pioneer Mutual Life Insurance Company
The State Life Insurance Company
Golden Rule Insurance Company

STATEMENT OF VARIABILITY

Policy Change Application
I-21431

Page		**Reason for Variability**
Page 1 Form Header	American United Life Insurance Company, Pioneer Mutual Life Insurance Company, The State Life Insurance Company	The name of each company is bracketed to permit deletion of a company or addition of a company authorized to do business.
Page 1 Form Header	Company Address and telephone number.	Bracketed to permit us to change the address or phone number, if necessary.
Page 1 Form Header	OneAmerica	Company logo has been bracketed in case it is changed.
Page 1	Check all that apply: American United Life Insurance Company Pioneer Mutual Life Insurance Company, The State Life Insurance Company, Golden Rule Insurance Company	The name of each company is bracketed to permit deletion of a company or addition of a company authorized to do business.
Page 1 & 2	**PART I - Requested Change** This section lists the types of policy changes available.	This section has been bracketed to allow the Company to discontinue an option or add an approved option in the future.
Pages 3, 4, 5 & 6	**PART II - New Policy Information and/or Requested Change Details** **SECTION 1: F, G, H, I, J, L**	This section has been bracketed to allow the Company to discontinue an option or add an approved option in the future.
Page 6	**SECTION 2: Change of Plan/ Death Benefit Option Change**	This section has been bracketed to allow the Company to discontinue an option or add an approved option in the future.
Page 6	**SECTION 3: Increase/ Decrease Base Policy/ Specified Amount or Rider**	This section has been bracketed to allow the Company to discontinue an option or add an approved option in the future.
Page 6	**SECTION 4: Addition/ Cancellation of Rider/ Benefit**	This section has been bracketed to allow the Company to discontinue an option or add an approved option in the future.
Page 12	Telephone Number for a printed version of the prospectuses: 1-800-537-6442	Bracketed to permit us to change the phone number, if necessary.
Page 13	AUL, PML, State Life	The name of each company is bracketed to permit deletion of a company or addition of a company authorized to do business.
Page 13 RECEIPT	American United Life Insurance Company, Pioneer Mutual Life Insurance Company, The State Life Insurance Company.	The name of each company is bracketed to permit deletion of a company or addition of a company authorized to do business.
Page 13	Company Address and telephone number.	Bracketed to permit us to change the address or phone number, if necessary.